ROGERS (J. G.)

FIRST AID FOR THE INSANE.

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Read, on invitation, before the MARION COUNTY MEDICAL SOCIETY at the Central Hospital for Insane, Indianapolis, April 10, 1898.

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EXPERIENCE has established the rule that all cases of marked insanity should be, as promptly as possible, placed in an institution devoted to the care of such cases. This is especially true in regard to those evincing decided maniacal symptoms, in which a few days only of lack of sleep, rest and food, together with the wear and tear of incessant frenzy, are needed to reach a termination in fatal exhaustion. Usually, however, the horrifying manifestations and great difficulties of care in instances of this type force, promptly enough, efforts towards commitment to a hospital, where, ordinarily, methods are available which successfully meet these elements of

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primary danger. It is very true, also, in the various types marked by general depression, mental and physical, for in these, hospital care affords better safeguards against the usually present tendency to suicide than can be possibly secured by domestic control of any sort, and, besides, as a rule, a more conservative and safer attention to the somatic conditions which usually underlie the psychic state. Indeed, in a greater or less degree, it is true in all cases, of all types, that early hospital care is desirable and for the best interests of the patients as such. Nevertheless, unfortunately, it is equally true that in the majority of instances there are circumstances and influences which conspire effectively to prevent a speedy commitment; often months elapse before conditions force this action, and, not infrequently, before this occurs death comes to close the argument and the case history at the same time.

Sometimes it happens that the patient can not be moved because of conditions due to disease or traumatic injury; sometimes aversion to the fancied stigma of a public announcement of diagnosis, or a fear and uncertainty as to institution

methods, begotten of ignorance and "red journalism," or sentimental adhesiveness, or failure to agree among themselves, prevent judicious action on the part of kindred or next friends, and, unhappily, it often occurs nowadays and in our own State that the patient can not be admitted to a hospital on account of lack of room.

In either event he remains at home, for a time at least, and it becomes the duty of the home physician to supervise the care of the case, a duty not usually sought for with enthusiasm for many reasons, but particularly because of difficulties, soon discovered, growing out of the general unfitness of things—especially lack of skilled nursing, lack of proper surroundings and means, and no lack at all of excited volunteer advisers and critics. The more serious the case the greater become the difficulties, but they exist in every instance, and the medical adviser is usually the first to advise, and even insist, on removal to an institution.

It is the object of this paper to discuss the home care of the insane; if it may fortunately be the

means of aiding any medical brother in the performance of this trying duty, the writer will feel himself fully repaid for his labor.

Early diagnosis is of the highest importance; not detailed differential diagnosis, but simply early detection of mental unsoundness. Has one to minister to a mind diseased with a train of deceptive manifestations obscuring the truth, or with actual, tangible morbid conditions of the body, or with real, extraneous relations, on the part of the patient, to other people and things? That is the first question. Insanity is a condition, due to disease, in which the faculty of judgment ceases to be guided by the experience of the individual in appreciating or accepting, or directing, or controlling, or applying the operations of the other mental faculties in part or whole. In every case the individual should be fully studied in order to determine what his mental action would be normally under given conditions, in other words, his normal mental experience. Failure to apply experience deliberately or automatically as a guide to action is a departure from the norm and indicates morbid mental conditions or insanity. I

know of no better guide in diagnosis than this rule, and, in a long association with the insane, have found it to be universally applicable. It matters not whether the person be congenitally defective or of the highest type of development. Insanity may be superadded to idiocy and so may it disturb the most highly wrought mind. In either case an abdication of normal experience from the control of mental function, in whole or part, is the pathognomonic sign. Lack of apparent reasonable motive for acts or thought expressions is evidence, *prima faciae*, of mental disease, and this rule suggests, in my judgment, the best primary test; but it is important that what would be reasonable to the individual in his normal state shall be used as the standard in any given case.

The influence which unsoundness of body always exerts on soundness of mind must always be considered and used as a side light on the main question. Undulations of mental tone, due directly to somatic depression or excitement, must not be taken for insanity. A broad application of foregoing principles will be a safeguard against any such erroneous conclusion. But, on the other

hand, there are many morbid conditions of the body which do exert a most decided influence in causing true psychoses.

It being determined that mental disease does exist, differential diagnosis is then to be attained as soon as practicable, for on this largely depends prognosis of the course and final termination of the malady—so important to be known in such cases on account of business, family and other relations. In most instances the diagnosis brings with it uncertainty as to duration, course and ending, but usually an approximate scheme of events may be made; in some it is a death warrant, as in general paresis and progressive chorea —postponed, but sure. Hence the importance.

Adopting the symptomatic classification now generally favored and in use in institutions in America, insane conditions may be properly arranged under three chief divisions—Mania, Melancholia and Dementia. An individual case may, in its course, present at different times all these conditions, in varying degrees of intensity and varying sequence.

The essential feature of mania is a series of delusions or false beliefs, disassociated, unsystemized, often ephemeral, expressed by words or acts or concealed, but accompanied always by more or less excitement of mind and body, often both noisy and violent; sometimes, however, silent, quiet and only shown by occasional acts and facial expressions, both requiring close observation to appreciate.

The chief character of melancholia is depression of mind and body.

Dementia is marked by mental dullness and apathy.

The more elaborate subdivision of the various insanities is based upon the combination, sequence, course, intensity and character of manifestation of the above named chief types and upon the somatic complications co-existent.

Various systems of classification have been urged upon the above basis. The following has been found to be fairly satisfactory and is generally used in the American hospitals for the insane. It has the advantage of simplicity and is well adapted for the use of the general practitioner.

CLASSIFICATION OF INSANITIES.

Mania, Acute.	Monomania.
Chronic.	Paranoia.
Epileptic.	General Paresis.
Melancholia, Simple.	Dementia, Primary.
Delusional.	Secondary.
Agitated.	Paralytic.
Stuporous.	Senile.

Special characteristics warrant, to some extent, further differentiation, but the above is sufficient for this discussion of the subject. As examples, however, it may be proper to note, Katatonia, Chronic Progressive Chorea, Puerperal, Recurrent and Traumatic or Surgical Mania, Circular Confusional and Pubescent Insanity, Hysteromania, etc. The many various phobias and manias with long Greek and Latin names constitute a refinement of classification of use only to the hair-splitting nosologist.

Acute Mania sometimes comes like a clap of thunder in a clear sky, wild and noisy frenzy being developed within a fraction of an hour,

without premonition, but usually certain prodromata can be noticed. Among the most important is insomnia. There is no better mental barometer than sleep; when it is out of sight look out for a storm. When it is persistently scant and fitful, in the absence of pain, a careful examination of every organ, every function and every habit should be made, environment should be studied, correction of evil conditions should be secured, as far as possible, by careful, conservative methods and the case watched closely. The use of hypnotics should not be postponed too long. In my opinion, nothing is better than chloral hydrate, in doses of 15 grains, in water 2 ounces, every fifteen or twenty minutes, for two or three times, the patient being recumbent and prepared for sleep. Often the first dose suffices. When there is decided debility, or a weak heart, an alcoholic stimulant should be given with the chloral as a safeguard, though in thousands of administrations without this I have remarked no decided depression as a result. Liebreich, its introducer, insists, however, that only the recrystallized, free of free chlorine, be used, and I

have followed his advice. With removal of irritating conditions, external and internal, quietude, rest, good food and sleep enough, even if forced by chloral hydrate or its equivalent, the danger may be bridged and health restored without further developments.

Should frenzy supervene or appear as the primary symptom, with incessant muscular activity and tendency to violence, some restraint will be required: Roll the patient up tightly in one or more sheets wrung from lukewarm water, the body being stripped of other clothing, or nearly so, the legs together and the arms close to the sides, like a mummy. Place him so on a narrow bed, and prevent rolling by a strong sheet stretched from rail to rail and fastened there. This done, still the delirium by a hypnotic, chloral hydrate by the mouth, as above, or by rectum in 30 grains dose, if possible; if not, give hyoscin hydrobromate from 1-50 to 1-20 grain hypodermically. The salient conditions are usually overcome for a few hours by these means and the patient sleeps. Constipation often exists, with accompanying intestinal toxis, and this demands

a clearance as soon as practicable, with preferably an active saline, if it can be given, otherwise by a dose of calomel, X gr., slipped into the mouth next the cheek or on the tongue, and large rectal irrigations, repeated every half hour till effective. Tendency to exhaustion must be additionally forefended by regular and sufficient food of a concentrated sort, sterilized by cooking preferably. While in the pack it may be liquid or semi-liquid, and is then best given with a feeding cup provided with a spout.

In the lulls of excitement, if such occur, restraint should be removed and a liberal meal may be taken in the usual way; and at such times exercise, with a proper attendant, in a quiet place, will be advantageous. If practicable, two or three drams of one of the alkaline bromides may be given daily, largely diluted, in divided doses, for a week or more, especially if the frenzy continues to be pronounced. Opium in any form is not indicated excepting there be physical pain due to disease or injury. Where possible, a daily warm bath will help to soothe and may be imperatively required to secure cleanness of body,

evacuations often being unannounced and disregarded by the patient. The hypnotic may be repeated nightly if required, but only to secure a few hours of sleep and the vital recuperation that comes with it, even when forced. It is better to omit this in the day time, for it can not throttle the disease, nor even effect it otherwise than indirectly by affording temporary rest. In dosage short of causing sleep promptly it is only a detrimental disturber. The bowels and bladder should be evacuated sufficiently and regularly, palpation over the abdomen being used at each visit to prove it. If there has been protracted constipation at the onset, 10 grains of salol may be given daily, after free purgation, for two or three days, as an anti-toxic, if the patient will take it properly. It is best given mixed with granulated sugar dry on the tongue and washed down by a draught of water.

Use restraint only when absolutely required, but if used it should be efficient. If the wet pack, before referred to, seems undesirable for any reason, it may be applied dry if the weather be

not too warm. If the patient be not in bed, mittens of leather or cotton duck firmly attached to a belt, buckled at the back, may be used. In an emergency, restraints may be made of sheets, roller towels and the like. A good rope, in conjunction with towel bandages, over hands and wherever needed, is a sure thing, but is lacking in elegance.

In the milder types of Mania, in which there are insomnia and changing delusions, but with excitement short of frenzy, the same therapeutic principles are applicable, but the means may be and should be modified somewhat. Personal care and control, day and night, is enough without mechanical restraint, and hypnotics and the bromides are needed only occasionally. The functions must be carefully regulated, toxic influences eliminated and nutrition especially fostered.

In all types cases must be considered individually and the conditions met according to the needs, but, as a rule, mend the body, clear it of poisons, rest it and feed it, and the brain will gradually resume normal function. In hospitals, recovery occurs in more than 50 per cent. of

cases of uncomplicated cases of Acute Mania; in homes and jails, not so many, but still, in the latter, often without anything whatever which could be called treatment.

The duration is usually from three to six months, recovery, however, being sometimes postponed to the eighteenth month. In fatal cases, death usually occurs early, in from one to four weeks, from exhaustion. Intercurrent disease is rare. In my experience, indefinite chronicity ensues in 20 per cent. of cases without dementia, and, with partial dementia, in about 10 per cent.

As to danger of recurrence, it can only be said that like causes produce like effects, but the statement is fully warranted that, in the majority of instances, after well established recovery, recurrence is not noted in the registers of the State hospitals. In short, the prognosis in Acute Mania is, without doubt, generally favorable. In the more complex insanities, in which mania occurs only from time to time as a temporary symptom, as in General Paresis, Epilepsy, etc., the plan of

treatment above set forth may properly be applied with required modifications to suit conditions.

Paranoia. Now and then the general practitioner must be the judge of the mental state in cases in which extraordinary acts and expressions, carefully considered, in the light of circumstances, lead up to the conclusion that they are based on a single delusion or group of parallel delusions, usually involving persecution, harm or injustice in some or many forms, to the individual in question. For nearly a century, following the suggestion of Esquirol, this mental condition was named Monomania, a very good Latin word which meant what it said; nowadays it is Paranoia, by convention or fashion—a Greek word conveying the idea of being out of one's head. The propriety of the new name appears doubtful.

Early diagnosis of this type is of the highest importance to the community. Unfortunately it often happens that it is first made in a criminal court after some outrageous and motiveless crime has been perpetrated, and then it is not often believed. Lack of reasonable motive is the best

criterion in such cases. The Paranoiac is usually intelligent, quiet, well ordered and rational, excepting in relation to his delusions, but these color more or less every thought and deed. Vanity, suspicion and sensitiveness are prominent characteristics. He has unlimited faith in himself and always thinks he is right, but he is usually a very unsafe citizen. Guiteau was a type.

As to treatment, he is inherently defective and usually incurable and requires only custodial safeguarding, and should have this as soon and as long as possible. It does occasionally occur, however, that the manifest symptoms disappear under proper care of a regular, quieting sort, and then the doom of lasting crankhood may be lifted and the citizen rehabilitated.

Melancholia. The simple, delusional, agitated and stuporous forms of Melancholia are all superstructures built on a first laid foundation of depression, combining both physical and mental manifestations, readily recognized, as a whole, by the medical adviser. As a rule, such cases are and may be properly kept at home (if it be a good one and a fit one), for a time at least; but the

danger growing out of the suicidal tendency, which is often concealed, must be kept in mind and guarded against constantly. Intelligent and judicious association and supervision is a most important factor of treatment in all cases of this class, and where not available commitment to hospital is proper without delay.

Functional and organic defects, and errors in daily life and habits, including those of the mind as well as body, should be carefully sought for and corrected as far as possible. There is always lack of tone, and tonics will be required in variety, with special reference to nutrition. The food should be of the best, regularly and sufficiently taken, by urging or by force if necessary. To this end, the nasal feeding tube is all that can be desired—simple, safe and easy to use, even under violent opposition. In the absence of the special tube furnished for this purpose by the instrument makers, an ordinary soft catheter (No. 12) may be attached to the rectal tube of a good soft rubber syringe and you will have all that is needed. The patient lies on a couch with the head bent

toward the sternum, so as to curve the pharynx, and the lubricated tube is passed directly back along the floor of the nose until, with gentle, progressive pressure, it takes the curve and enters the esophagus several inches and is held there by the left hand; then, from a neighboring pitcher, held by an attendant, the right hand deliberately pumps out into the stomach a mixture of two or three eggs and a pint or more of milk, well beaten and previously warmed or Pasteurized at 165° F. Restraint may be required, but this is rarely so. The operation should be repeated twice daily, always by the physician. If there are signs of suffocation or strangling, on introduction, the tube has gone wrong; withdraw it and try again, being careful to keep the nose in the median line. Very little practice makes one expert, if he knows the anatomy of the throat.

In Melancholia, the faculty of attention is always at fault; words pass in one ear and out the other; the mind's eye sees only the pictures which the imagination bodies forth, and pays little heed to external perceptions; the needs of the body are unfelt or disregarded more or less; sensation,

even to pain, is blunted, and, in some cases, in which catalepsy occurs, the concentration of attention is so intense that there seems to be complete inhibition of all mental, motor and sensory function and the patient is said by the layman to be in a trance, during which life is so modified as to be but little removed from mere vegetation. Sometimes this state may continue for years.

In many cases of Melancholia much can often be accomplished by "talk"—large and vigorous doses of logic regularly repeated. The physician may well spend time in a series of judicious drills in mental gymnastics, in which attention shall be first developed; this done so that the ear of the patient is opened, the logic may be poured into the brain, and some of it will take root sooner or later and grow to a healthful plant, unless the ground be already too barren from the changes incidental to established dementia. Persistence will often be rewarded most remarkably after a time, and mind and body, hand in hand, will join in the return to vigorous health.

Prognosis is favorable in 50 per cent. of cases; the duration in recovered cases is from six months

to three or four years. Change for the better comes slowly at first. Permanent dementia may ensue and death may occur from intercurrent disease, often acute and inflammatory; not rarely malignant, for the melancholiac offers defective resistance to morbific influences.

General Paresis. An elaborate practical knowledge of General Paresis is not to be expected of the general practitioner for the reason that he rarely has an opportunity to study its clinical history excepting in its primary stages. When fully developed, conditions are such as to force committal of the patient to an institution in almost every case, usually under a diagnosis of Mania, Melancholia, or what not, according to the prominent symptoms, and his physician sees him no more. But in view of its insidious approach, the sly mutations of character and conduct in its victims, and its fell nature when developed, every physician should certainly have at least an acquaintance with the outlines of this fatal disease and particularly with its primary symptoms, for in no mental malady is early diagnosis of greater importance, not only to the patient and his family,

but to the community in which he lives. When a Mr. Hyde, who has reached middle life with a reputation for sobriety, morality, caution, judgment, integrity, civil rectitude and general conservatism, is quietly converted into a Dr. Jekyl, who takes to wine and women, or reckless speculation, or extravagance in spending or giving, or inordinate boasting, or swindling, or general disregard of social and civil rules, in aversion from former tendencies, it may be that disease is at the bottom of it all, and then it is to the physician that falls the duty to be the first to suspect this and to lead the investigation which will develop the truth, for the protection of the community as well as of the irresponsible culprit.

General Paresis is a disease of middle life, much more frequently affecting men than women, involving both mind and body and leading invariably, as far as observed and recorded, to a fatal termination in from two to five years. The salient motor symptoms are those of ataxia—incoordination of muscular movement, absence of reflexes, notably the patellar and pupillary. The tongue, when protruded, is tremulous, speech is

quavering, the gait is uncertain, penmanship is deteriorated and shaky, the pupil is often small and irresponsive to changes of light, and deglutition is defective, sometimes to the extent of choking. At long intervals usually, convulsions may occur, sometimes followed by apoplexy of a fatal sort, and temporary paralyses are not uncommon.

The sensory symptoms are also those of ataxia and are varied according to the location and degree of irritation or degeneration in the spinal cord. Localized anasthesia or hyperesthesia may be manifest and should be sought for. Frequently lightning-like pains pervade the thorax and cause momentary outcries from the patient, who is unable to explain, and hence they are taken for signs of temporary rage by uninformed attendants. Trophic changes, especially in the skin, are very apt to occur. Bed sores, deep and extensive, are often rapidly developed, after a few days in bed for any cause, in the terminal course of the disease.

The mental symptoms are varied, and not characteristic when considered alone. There may be

Mania, Melancholia or Dementia in varied sequence and degree, according to the stages of the disease. A radical subversion of mental and moral tendencies or an unsymmetrical exaggeration of some of these, accompanied by greater or less exaltation, is usually the first mental sign given. Sooner or later, grandiose delusions are very commonly prominent. The patient is stronger, better, happier and richer than anybody, and insists on sharing his wealth and happiness with everybody. Fortunately this fancied well-being lasts to the fatal end. Whatever the nature of the delusions, they are usually of a happy sort; not always, however, sometimes they are distressing enough, but even then the patient generally sees a silver lining in his dark cloud; absolute melancholy is rare, and I know of no instance of a paretic suicide. Dementia comes in the latter stage as a result of progressive organic lesion. Aphasia and agraphia are not uncommon long before dementia is declared. Spoken language may be reduced to a few words, repeated to convey every idea, and, in writing,

words are incessantly repeated or omitted to such extent as to destroy sense.

In no case, at any one time, are all these symptoms conjoined. Sometimes the motor conditions are most prominent or precede the mental degeneration, and, *vice versa,* the latter may exist or may have progressed to a marked extent before there are any pronounced signs of muscular trouble. This relation depends upon the relative progress of the lesions of the cord and those of the cerebrum. Certain symptoms may be entirely absent during the whole course of a given case, but all cases bear a resemblance to the standard described. As an aid to diagnosis, it is important that the medical adviser bear in mind the following suggestion: Where ataxia, however slight, or however manifested, exists together with marked change of character or conduct, suspect Paresis. Where marked and motiveless changes of character and conduct arise, which are inexplicable by any apparent conditions of disease or injury, especially if attended by grand and fanciful ideas, await ataxia and expect Paresis.

The prognosis is always unfavorable, though remarkable periods of arrest have been observed. In my own *clientele* are two cases who have been actively engaged in business away from the hospital for three years and whose friends deem them well; I expect them to return, however.

This disease can not be said to constitute any part of the history of syphilis, yet it is nevertheless true that in nine out of ten cases a story of luetic infection, ten or twenty years before, may be obtained, and there can be no question that such infection, whether well treated or neglected, establishes a predisposition to Paresis. Vocation, too, seems to have its influence in this direction. I have observed for years the preponderance of railway engineers, conductors and mail agents among its victims.

Cure there is none, but the way may be made smoother by obvious symptomatic treatment according to principles before referred to.

Dementia, or pathological mental dullness, is usually secondary or terminal insanity, following the more acute states, but occasionally a case appears in which the normal mind is rapidly covered

with a fog, not due to melancholy or any other assignable depressing condition; to such has been given the name of Acute or Primary Dementia. The prognosis is uncertain. In this, as well as in all other types of this class, the treatment is symptomatic.

Pathology. I have made little else than a passing reference to pathological conditions because more is uncalled for here and because, though neurology is rich in its findings in this direction, the ultimate secret of how men think, whether sane or insane, is still hidden from all men, and none of the many lesions found can be definitely assigned to any mental state beyond question, and the wise seeker after truth must remain still an agnostic.

LONGCLIFF, near Logansport,
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